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REPLY: Medical Malpractice Litigation

A Fellow's Perspective

I appreciate the comments of Dr. Lazarous and colleagues on my editorial (1) and strongly welcome the efforts to introduce educational activities relating to the avoidance and handling of cases of medical malpractice litigation to training curricula of residents and fellows.

On the other hand, although it would be ideal to describe the process of being involved in a legal patient complaint related to medical practice as mere "professional liability," the unfortunate reality is different. As Dr. Lazarous and colleagues correctly stated, in the majority of these legal cases, no fault is found. Nevertheless, the effects of these cases on the involved physicians, who not infrequently suffer significant psychological stresses, may be more compatible with the claims being malpractice. In these cases, physicians are accused of being negligent enough to cause patient harm, rather than just being part of an unfortunate event during their practice. In fact, there is evidence that the negative effects of these accusations are profound enough to extend to those not directly involved in these cases. In a recent survey of cardiologists and cardiology fellows (2), surveyed participants reported that the fear of malpractice litigation influences clinical decisions and may increase unnecessary cardiovascular testing. There was no difference in these survey responses between those with and without prior involvement in malpractice, which may reflect the spreading effect of malpractice accusations on other physicians in the same field. Educating physicians, as well as introducing tort reform, are therefore imperative to offset what has been described a malpractice crisis (3) while ensuring patients are safely treated to the best possible standards.

***Marwan Badri, MBChB**

*Lankenau Medical Center and Lankenau Institute of Medical Research
100 Lancaster Avenue
Wynnewood, Pennsylvania 19096

E-mail: marwanbadri@gmail.com

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Therapeutic Goals in Patients With Acute Aortic Dissection

Management Before Surgery

We read with great interest the review article on thoracic aortic aneurysms and dissection by Goldfinger et al. (1) in the *Journal*. The authors do an exceptional job in summarizing the epidemiology, major risk factors, and management options in patients with aortic aneurysms and dissections. However, we would like to bring the reader's attention to several critical treatment and transfer management options specifically for patients with acute aortic dissection.

Although surgery remains the primary mode of treatment for patients with Stanford type A dissection, the majority of patients with aortic emergencies present to smaller community hospitals and emergency facilities without onsite surgical expertise. These patients require transfer to larger tertiary centers for surgical consultation, potentially leading to delays in treatment. Efficient triage, diagnosis, and transfer is critical because, as Goldfinger et al. (1) point out, the acute unoperated mortality for type A dissection is 1% to 2%/h during the first 48 h. Not surprisingly, even with improvement in diagnostic capability and surgical techniques, mortality remains high (2). In this scenario, pre-operative management in these patients is paramount. Goals during this stage of management include aggressive control of blood pressure and heart rate (dp/dt), clinical stabilization, and ensuring rapid and safe transfer to tertiary centers. The important role of clinicians at the initial site of patient presentation and that of the transfer teams in achieving these therapeutic targets cannot be understated. Although surgery is the definitive goal, control of blood pressure and heart rate will help reduce progression of dissection and development of end-organ damage, thereby